

WHO DELIVERS PRIMARY CARE IN GROUP PRACTICE?*

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PRIMARY care in group practice can be considered in four broad areas, perhaps most readily as questions:

- 1) What characteristics of group practice enhance the possibilities of providing primary care?
- 2) What characteristics of group practice make primary care more difficult?
- 3) What is the group doing that is constructive in developing primary-care relations?
- 4) What are the areas about which we have reservations or in which we so far have been unsuccessful?

The features of group practice which facilitate the developing and continuing of a primary-care relation include the size of the group; its mixture of physicians, nurses, and other staff; its organizational potential for designing and implementing medical-care systems; and its resources in administrative and clerical staff which enhance the ability to reach out and involve the patient. Further, the existence of a geographic entity, the group center, which is the locus for ambulatory care, further focuses the member's concept of a central entity to which he turns for care.

While the solo practitioner could be, and often is, an appropriate person to assume the responsibility for primary care, some solo practitioners either are harassed by the demands of solo practice or simply are not interested in taking on this task. Thus, the patient under the care of an otherwise excellent physician may receive or sense no invitation for ongoing counseling or treatment other than those directly associated with the original complaint. Group practice, by virtue of its additional resources and ease of referral, can be designed to encourage this care by providing availability and accessibility. Some groups may choose to incorporate sophisticated data-processing

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technology which, for example, can identify each person's birth date so that he may be reminded to return for annual examinations—the value of which, appropriately, now are being questioned—or summon the six-month-old infant who has failed to appear for his immunization. One can argue the virtue of sophisticated equipment versus that of sophisticated personnel in the arenas of cost effectiveness, reliability, and sociability, but at least both paths are available.

Another potential of group practice as the provider of primary care is that it affords the opportunity to establish small satellite centers offering care by the internist, pediatricians, obstetrician, family physician, nurse-practitioner, or whatever combination of personnel best meets the local needs. Well-trained staff in well-equipped facilities, thus, can be induced to practice and remain in areas which might otherwise be unattractive and which, without such a subcenter, might be without a source of primary care of acceptable standards.

Group practice has an incentive in developing a primary-care relation since it reduces the problem of the “free-floating” patient who is seen with great inefficiency by different primary physicians; these patients seem to have more “emergencies,” more “walk-in appointments,” and more broken appointments. The group's interests as well as those of the patient are served best when the patient can identify an individual as responsible for providing or directing him in his search for health care.

One last point I would make relates to the longevity of the group. When the practice of a solo physician is terminated many patients are left with a feeling of abandonment; they are concerned about finding a new physician and about what will become of their medical records. The patient in the group practice does not experience this same degree of discontinuity since the remaining, familiar staff and the preservation and availability of records preserve to a large degree the feeling of continuity of care.

Now for the characteristics of group practice which differ significantly from fee-for-service practice and which make the establishment of the primary-care relation more difficult. One such characteristic stems from the fact that the patient who joins a group usually does not request a specific physician who may have been recommended by a friend. The group physician starts from zero to develop a relation with the patient, whereas the solo physician merely has to sustain the positive feeling the patient has already developed. Another difference—a corollary of the first—is that a patient entering a group, particularly a newly formed group, without having had a

specific physician recommended sometimes may transfer from one physician to another with whom the patient feels more at ease. The group facilitates such transfer through the continuing availability of the same medical records, the presence of the same ancillary staff, and the same geographical area. Thus, the patient does not experience the difficulties he may feel in going from the office of one solo practitioner to another. This may encourage the patient to transfer more often and delay the identification of one physician as the primary doctor.

A third characteristic of group practice which may add to the difficulty in developing a primary-care relation is the possibility that the patient erroneously may think that he has the right to see specialists on request. This is undesirable from the patient's and the group's point of view, as it may fragment medical care, utilize expensive resources when others might be more appropriate, and assign to the patient the judgment as to his need for specialists when his problem might more appropriately be dealt with by the generalist or, perhaps, by a different specialist. Self-referral to a specialist is not the policy of the group and is not the way the patient gains access to consultants, with the exceptions of gynecology, ophthalmology, and optometry. These differences—the belief of the patient that he has joined a program rather than selected a doctor, that a change of physician is not difficult, and that he has ready access to specialists—are among the problems the group must solve if it is to establish and provide unified, continuing primary care.

Now some comments about our group, the Community Health Program of Queens-Nassau, a 2 1/2-year-old prepaid group practice with 12,000 members. It was born of the joint efforts of Long Island Jewish-Hillside Medical Center and Blue Cross/Blue Shield of New York. I shall describe the approach that has evolved in our medical group not because it is meeting all needs, but because it is the best we have been able to devise thus far; it is better than our earlier efforts, but still needs to be modified and improved. I am not certain that it is a system so much as an attitude or, perhaps, a philosophy.

“Who delivers the primary care?” is the wrong question. “Who assumes the responsibility for assuring the provision of primary care?” is more helpful. I am uncomfortable with the team concept since a team is often a health system's euphemism for a committee and I am not pleased with the ratio of input to output of most committees. An individual has to assume the responsibility for medical care. I am not recommending elimination of the team concept, but rather suggesting that the patient's needs and the team's

needs may be confused; the patient may have neither the strength, inclination, nor the time to cope with the receptionist, nurse, physician, and social worker.

The locus of primary care in our group is not always the same person nor the same system. There are, and should be, multiple points of entry. In some instances a sophisticated parent is the most important party in assuring continuing comprehensive care, with the group personnel assuming the responsibility for the availability, accessibility, and competence of care. I see no reason why the parent or patient should not be the key person. The various components of the group assist and help define priorities, dealing in one way with the much-publicized and ever-present "worried well" and in a different fashion with the group about whom I have more concern, the "inarticulate ill," who always seem to be at the end of the health-care line.

To reach these inarticulate ill and at the same time introduce new members to the program, we now have one of the nurse-practitioners telephone the new subscriber (preferably the wife), introduce herself and describe her role, welcome the subscriber, elicit an abbreviated history of the individual or the family, and advise and facilitate early care if any significant illness is perceived. At the same time appointments for the entrance examinations are advised or scheduled for the remainder of the new members, depending upon the availability of time.

Other patients enter primary care in connection with a specific health problem and in the course of its being dealt with select the person who best fits their needs. Perhaps an amiable internist may be the one who is interested or possessive enough to invite the patient to telephone or return, or it may be an empathetic nurse-practitioner working with a physician who lacks these characteristics. Pregnant and formerly pregnant women look to their obstetricians and obstetrical nurse-practitioners as fellow members of an exclusive club; the patient goes outside this clique for advice only when, for example, the obstetrician modestly acknowledges that he is a little out of touch with recent advances in open-heart surgery. While we have set up an organization teaming nurse-practitioners and pediatricians or internists together with patients' representatives to facilitate the patient's gaining access to care, patients have often modified, skirted, or totally ignored our plan and developed a methodology suited to their own needs. This is as it should be. When the patient feels that he has made contact with a nurse or physician who cares enough to assume responsibility for his care, the first major obstacle has been resolved. The success or failure of the system is not so much a function of its

design as of the nature of the people involved. We can assume that professional competence is a given factor; the curriculum vitae tells us that, but it takes time to discover those who declare a concern for mankind but really do not like people. This is the source of most problems.

What problems or difficulties are we still trying to resolve? I have not defined primary care, but have dealt rather with personnel, organization, and techniques by which we attempt to involve the patient or have him involve himself in a participatory relation with the provider of care. There are patients we either are not reaching or are not “connecting” with. Some people are difficult to care for—possibly for psychodynamic reasons; they constitute our recurring failures. They may not be many but these patients are ever present; we have not yet been able to develop an approach that they can afford and accept. In fee-for-service practice they go from doctor to doctor—the problem either is not perceived or is not addressed. In prepaid group practice we must develop a better technique than we have; we must recognize the problem and offer the patient a solution other than repetitive visits, x-ray examinations, and specialist referrals. The inclusion of limited psychiatric benefits in Health Maintenance Organization legislation may be a partial solution.

Another concern relates to the risk of the over-design. Have we health-care providers developed enormous conceit regarding our capabilities and our responsibilities? In doing so have we stimulated a mass regression, aiding and abetting an unrealistic dependency upon the physician, nurse, psychologist, social worker, tranquilizer, or our whole cabal, when we really are not the all-knowing experts nor have the capability of filling the enormous need for care, support, and solutions? Once the physician was not reluctant to accept the role of a God-like creature, but now he is too disinterested, busy, or, perhaps, realistic to behave even as a minor deity, although an occasional genuflection may be appreciated. I would advocate a more modest assessment of the capabilities of the provider and the assumption of more responsibility by the patient. No one party delivers primary care. Only when both the provider and the recipient cooperate can care be delivered and interaction take place. The patient often is more effective in keeping himself well than the provider is in making him well. I must exclude those individuals who are medically unsophisticated or have other valid reasons for being unable to assume this role. For the many others, are we promoting the theory that people are incompetent and thus require shoving into the physician's office, like-it-or-not or need-it-or-not, for ongoing supervision and control?

Almost all of my discussion has been devoted to the “who” and “how” of primary-care delivery. The “what” of primary-care has been described by others. I shall briefly point out what may be significant differences between fee-for-service and prepaid group practice which may modify the allocation of resources in making adequate primary care accessible. In ambulatory care often the patient rather than the provider determines when and how much health care is utilized; this can be especially true in a prepaid practice where the fee per visit is no longer a deterrent. The medical group will have to establish priorities in such areas as staffing, e.g., generalists versus specialists, time allocations, e.g., routine screening programs versus acute problem intervention, and so on. A prepaid group where the financing is not open-ended, in contrast to a fee-for-service practice, must distinguish wants from needs. The wants may be extravagantly wasteful; the needs must be readily available. At a time when funds for health care, be it fee-for-service or prepaid group practice—along with housing, education, basic research, and nearly all social problems—are experiencing constraints, it would be both naive and immoral not to make value judgements. What is the impact on morbidity and mortality of the periodic examination, the sixth annual Papanicolaou smear, routine sigmoidoscopies, the cholesterol determinations which are followed by patients with an avidity comparable to that of a devotee reviewing his racing sheets, and the countless miles of electrocardiograms? It has become a cardinal sin to smoke, drink, be accident-prone, or ignore the need to get calories and the blood-pressure pills down and muscle tone up. Therapeutics has developed a subspecialty, behavior modification, known to its friends as compliance and to its enemies as coercion.

A *modus operandi* which is noncontrolling and totally permissive may mean that the individual's preferences have been protected while society assumes the costs. The alternative is more control of the individual, modification of his behavior, perhaps with intellectual rather than electrical prods, and a resultant diminution in costs to society. It is the difference between printing on cigarette packs the slogan: “Warning: The Surgeon General Has Determined that Cigarette Smoking is Dangerous to Your Health” and randomly scattering exploding cigarettes in each pack. It is a difficult decision, but one that is relevant to the direction one pursues in health education. It is the difference between posters and discussion groups on one hand and negative conditioning and positive reinforcements on the other. The question is which is the better technique for group practice—not which is more effective, but which is more appropriate in good medical care?

I have suggested some of the features of group practice that make easier and some that make more difficult the provision of primary care and the establishment of the relations that are a prerequisite for this care. No over-all plan has been proposed; rather a narrative on what is taking place has been presented. More effort is required to get started in group practice than in solo practice, but once established group practice may be more varied and more secure since it is not dependent upon a single individual; it may be broader and better insulated because of the many back-up resources. There are problems still to be solved. Each group must make certain not only that its size and complexity will not be a hindrance, but that, by virtue of its appropriate definition of priorities and its adaptability, the group will assure that primary care is available, affordable, and accessible.